Severe Illness (ICU Admission) or Death in Pregnant or Postpartum Woman
Case Report
Centers for Disease Control and Prevention
Wisconsin Division of Public Health

Instructions: Providers are requested to use this form to report all pregnant and (up to 6 weeks) postpartum women with severe influenza (of any type) admitted to an intensive care unit (ICU), or who died. Please fax forms to the Division of Public Health at 608-261-4976.

Case ID:	
Medical record number:	
Contact name:	
Contact phone:	
Contact e-mail:	
Hospital name:	
Hospital zip code:	
Patient name:	
Patient DOB:	
State and county of residence:	

1. Patient Race:
☐ White
☐ Black/African-American
☐ Asian/Pacific Islander
☐ American Indian/Alaskan Native
☐ Other
☐ Unknown

2. Patient Ethnicity:
☐ Hispanic
☐ Non-Hispanic
☐ Unknown

3. Insurance Type:
☐ Private health insurance
☐ Medicaid
☐ Self-pay
☐ Uninsured
☐ Unknown

4. Pregnancy classified as high-risk? ☐ Yes ☐ No ☐ Unknown

5. Underlying medical conditions/risk factors:
☐ Asthma
☐ Other chronic lung disease
☐ Pre-existing diabetes (prior to pregnancy)
☐ Gestational diabetes
☐ Obesity (prior to pregnancy)
☐ Cardiovascular disease, excluding hypertension
☐ Hypertension (prior to pregnancy)

☐ Gestational Hypertension/Preeclampsia/Eclampsia
☐ Seizure disorder
☐ Neurodevelopmental and/or neuromuscular disorder
☐ Tobacco use during current pregnancy
☐ History of tobacco use
☐ Immunosuppression, specify_____
☐ Cancer diagnosed in last year
☐ Hemoglobinopathy
☐ Renal disease
☐ Other, specify:_____
☐ Unknown

6. Prenatal medications upon admission to hospital:

7. Estimated due date? __/__/__ ☐ Unknown

8. Gestational age at admission (wks): ____ ☐ Unknown

9. Date of symptom onset: __/__/__ ☐ Unknown

10. Date initial care sought: __/__/__ ☐ Unknown

11. Did mother receive rapid influenza test? ☐ Yes ☐ No ☐ Unknown
Result of rapid test? ☐ Positive ☐ Negative ☐ Unknown

12. Did mother receive rRT-PCR test? ☐ Yes ☐ No ☐ Unknown
Result of rRT-PCR test? ☐ Positive ☐ Negative ☐ Unknown

13. Did mother have any viral cultures? ☐ Yes ☐ No ☐ Unknown
Result of viral cultures? ☐ Positive ☐ Negative ☐ Unknown

14. Did mother receive DFA/IFA test? ☐ Yes ☐ No ☐ Unknown
Result of DFA/IFA cultures? ☐ Positive ☐ Negative ☐ Unknown

15. Did mother receive any influenza vaccine in 2009 or 2010 more than 2 weeks before onset of illness? ☐ Yes ☐ No ☐ Unknown
If yes, 2009 seasonal flu vaccine? ☐ Yes ☐ No ☐ Unknown
2009 pandemic H1N1 vaccine? ☐ Yes ☐ No ☐ Unknown

16. Did mother take antiviral medications before and/or after becoming ill?
☐ Yes (list below) ☐ No ☐ Unknown

□ Oseltamivir (Tamiflu®)	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Zanamivir (Relenza®)	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Rimantadine	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Amantadine	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Other	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____
□ Unknown antiviral	Dose _____ ____ times/day Dates taken from ____/____/____ to ____/____/____

17. Date of hospital admission: __/__/__ ☐ Unknown

18. Admitted to ICU? ☐ Yes ☐ No ☐ Unknown

19. Date of ICU admission: __/__/__ ☐ Unknown

20. Date of Final ICU discharge: __/__/__ ☐ Not yet discharged ☐ Unknown

21. Date of hospital discharge/death: __/__/__ ☐ Not yet discharged ☐ Unknown

22. Maternal death? ☐ Yes ☐ No ☐ Unknown

23. Other medications during hospitalization:
☐ Antibiotics
☐ Antihypertensives
☐ Vasopressors
☐ Systemic corticosteroids. If yes, please specify reason (*e.g.* for maternal health or fetal lung maturity) _____
☐ Nebulized drugs (*e.g.* albuterol)
☐ Antiepileptics
☐ Antiglycemics
☐ Tocolytic agents
☐ Diuretics
☐ Other, specify:_____
☐ Unknown

24. Was mother diagnosed with:

Pneumonia ☐ Yes, date: __/__/__ ☐ No ☐ Unknown

If pneumonia, was a bacterial culture obtained? ☐ Yes ☐ No ☐ Unknown

What was the culture site?_____

Result of bacterial culture? ☐ Positive ☐ Negative ☐ Unknown

ARDS ☐ Yes, date: __/__/__ ☐ No ☐ Unknown

25. Did she require mechanical ventilation?

☐ Yes, then how many days?_____ ☐ No ☐ Unknown

26. Date of delivery: ___/___/___ ☐ Unknown

27. Delivery location:

☐ labor and delivery
☐ emergency department
☐ intensive care unit
☐ Other, specify:_____
☐ Unknown

28. Method of delivery:

☐ Undelivered
☐ Vaginal
☐ Cesarean, scheduled
☐ Cesarean, emergency
☐ Unknown

29. Other delivery details/complications:

30. Delivery Outcome:

☐ Live birth
☐ Stillbirth
☐ Unknown

31. Gestational age at delivery (wks): ____

32. Infant birthweight: _____ ☐ Unknown

33. Infant 1-minute Apgar? ____ ☐ Unknown

34. Infant 5-minute Apgar? ____ ☐ Unknown

35. Infant to NICU? ☐ Yes ☐ No ☐ Unknown

36. Date of infant discharge/death: __/__/__ ☐ Unknown

37. Infant death? ☐ Yes ☐ No ☐ Unknown

38. Infant conditions during hospitalization?

☐ Skin rash
☐ Fever
☐ Temperature instability
☐ Bradycardia
☐ Apnea
☐ Petechiae
☐ Chorioretinitis
☐ Cataracts
☐ Seizures
☐ Meningitis
☐ Other neurologic abnormality, specify:_____
☐ Hearing loss
☐ Pneumonia
☐ Sepsis
☐ Respiratory distress, specify presumed cause: _____
☐ Other, specify_____
☐ Unknown

39. Infant outcome (any details regarding isolation, antivirals, or complications)**:**

40. Narrative (relevant details including rationale for delivery, overall clinical course)**:**